

Case Number:	CM14-0075516		
Date Assigned:	07/16/2014	Date of Injury:	07/25/2006
Decision Date:	08/22/2014	UR Denial Date:	05/19/2014
Priority:	Standard	Application Received:	05/23/2014

HOW THE IMR FINAL DETERMINATION WAS MADE

MAXIMUS Federal Services sent the complete case file to an expert reviewer. He/she has no affiliation with the employer, employee, providers or the claims administrator. The expert reviewer is Board Certified in Orthopedic Surgery, and is licensed to practice in California. He/she has been in active clinical practice for more than five years and is currently working at least 24 hours a week in active practice. The expert reviewer was selected based on his/her clinical experience, education, background, and expertise in the same or similar specialties that evaluate and/or treat the medical condition and disputed items/services. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

CLINICAL CASE SUMMARY

The expert reviewer developed the following clinical case summary based on a review of the case file, including all medical records:

The injured worker is a 66-year-old male who reported an injury on 07/25/2006 after he was struck by a heavy piece of iron. The injured worker reportedly sustained an injury to his left upper extremity. The injured worker's treatment history included physical therapy, a home exercise program, anti-inflammatory medications, forearm immobilization, multiple medications, and a TENS Unit. The injured worker was evaluated on 03/28/2014. It was documented that the injured worker had continued neck and left upper extremity pain complaints and left arm hypersensitivity. It was noted that surgical intervention was pending authorization by another treating physician. Physical findings included restricted range of motion of the cervical spine with palpable paraspinal trigger points. The evaluation of the left shoulder documented decreased range of motion with acromioclavicular tenderness and a positive acromioclavicular joint stress test. It was also noted that there was tenderness over a medial scar of the left arm with allodynia and hyperpathia with decreased grip strength at 40 pounds on the left versus 80 pounds on the right. Injured worker's treatment plan included exploration of the medial and lateral antebrachial cutaneous with neurectomy of muscle transplantation. The injured worker was evaluated again on 05/09/2014. Was documented that the injured worker had ongoing pain complaints and sexual dysfunction. A request was made for medications, to include Cymbalta and Lunesta. The injured worker's clinical documentation indicated that the injured worker had been on these medications since 08/2013. The use of viagra was initiated at this appointment. Injured worker's diagnoses included cervical spondylosis, left shoulder impingement syndrome, possible adhesive capsulitis, possible left arm neuroma, neuropathic and myofascial pain syndrome.

IMR ISSUES, DECISIONS AND RATIONALES

The Final Determination was based on decisions for the disputed items/services set forth below:

Exploration of the medial and lateral cutaneous, neurolysis, and muscle transplantation:
Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 11 Forearm, Wrist, and Hand Complaints.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 11 Forearm, Wrist, and Hand Complaints Page(s): 270-271.

Decision rationale: The requested exploration of medial and lateral cutaneous neurolysis and muscle transplantation is not medically necessary or appropriate. The ACOEM recommends surgical intervention for injured workers with forearm, wrist, and hand complaints be supported by significant functional deficits identified upon examination supported by diagnostic studies. The clinical documentation submitted for review did not provide any evidence of an MRI, electrodiagnostic study, or diagnostic injections to support the need for surgical intervention at this time. Additionally, the clinical documentation submitted for review does not provide significant exam findings to support the need for surgical intervention at this time. As such, the requested exploration of medial and lateral cutaneous neurolysis and muscle transplantation is not medically necessary or appropriate.

Cymbalta 60 mg QTY 90: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Antidepressants for chronic pain Page(s): 13.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Medications for Chronic Pain and Anti-depressants, page(s) 60 and 13 Page(s): 60, 13.

Decision rationale: The requested Cymbalta 60 mg quantity 90 is not medically necessary or appropriate. California Medical Treatment Utilization Schedule does recommend the use of antidepressants in the management of chronic pain. The clinical documentation does indicate that the injured worker has been on this medication since at least 08/2013. California Medical Treatment Utilization Schedule recommend that medications used in the management of chronic pain be supported by documentation of functional benefit and evidence of pain relief. The clinical documentation submitted for review does not provide any evidence the injured worker has any pain relief of functional benefit resulting from the use of this medication. Therefore, continued use would not be supported. Furthermore, the request as it is submitted does not clearly identify a frequency of treatment. In the absence of this information, the appropriateness of the request itself cannot be determined. As such, the requested Cymbalta 60 mg quantity 90 is not medically necessary or appropriate.

Lunesta 3 mg QTY 90: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Work Loss Data Institute (ODG) Guidelines-Pain (Chronic), updated 5/15/14.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain Chapter, Insomnia Treatment.

Decision rationale: The requested Lunesta 3 mg is not medically necessary or appropriate. California Medical Treatment Utilization Schedule does not address this medication. Official Disability Guidelines recommend short term usage of pharmacological interventions for insomnia related to chronic pain. The clinical documentation submitted for review does indicate that the injured worker has been on this medication since at least 08/2013. Furthermore, the clinical documentation does not provide an adequate assessment of the injured worker's sleep hygiene to support continued use. Additionally, the request as it is submitted does not clearly identify a frequency of treatment. In the absence of this information, the appropriateness of the request itself cannot be determined. As such, the requested Lunesta 3 mg quantity 90 is not medically necessary or appropriate.